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Veterans' Medical Care: FY2008 Appropriations

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Summary

The Department of Veterans Affairs (VA) provides benefits to veterans who meet certain eligibility rules. Benefits to veterans range from disability compensation and pensions to hospital and medical care. The VA provides these benefits through three major operating units: the Veterans Health Administration (VHA), the Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA). The VHA is primarily a direct service provider of primary care, specialized care, and related medical and social support services to veterans through the nation's largest integrated health-care system.

On February 5, 2007, the President submitted his FY2008 budget proposal to Congress. The total amount requested by the Administration for the VHA for FY2008 was \$34.6 billion, a 1.93% increase in funding compared with the FY2007 enacted amount. For FY2008, the Administration was requesting \$27.2 billion for medical services, \$3.4 billion for medical administration, \$3.6 billion for medical facilities, and \$411 million for medical and prosthetic research.

On June 15, 2007, the House passed its version of the Military Construction and Veterans Affairs Appropriations bill (MILCON-VA appropriations bill) for FY2008 (H.R. 2642, H.Rept. 110-186). H.R. 2642 provided \$37.1 billion for the VHA for FY2008. This amount included \$29.0 billion for medical services, a \$1.9 billion (6.9%) increase above the President's request. H.R. 2642 also included \$3.5 billion for medical administration, \$69 million above the Administration's request of \$3.4 billion; \$4.1 billion for medical facilities, a 14% increase over the President's request; and \$480 million for medical and prosthetic research, a 17% increase over the President's request of \$411 million. H.R. 2642 *did not* include any bill language authorizing fee increases as requested by the Administration's budget proposal for the VHA for FY2008.

On September 6, 2007, the Senate passed MILCON-VA appropriations bill for FY2008 (H.R. 2642, S.Rept. 110-85) with an amendment. H.R. 2642, as passed by the Senate, provided a total of \$37.2 billion for the VHA. This amount included \$29.1 billion for medical services—a \$3.2 billion (12.3%) increase over the FY2007 enacted amount and \$1.9 billion over the FY2008 budget request—and \$3.5 billion for medical administration, \$75 million above the FY2008 Administration's request. Furthermore, H.R. 2642, as passed by the Senate, provided \$4.1 billion for medical facilities, and \$500 million for medical and prosthetic research. The Senate-passed bill also *did not* include any bill language authorizing fee increases as requested by the President.

The Consolidated Appropriations Act, 2008 (H.R. 2764) was signed into law (P.L. 110-161) on December 26, 2007, and included the MILCON-VA Appropriations Act for FY2008. Under P.L. 110-161, the total amount of funding for the VHA is \$37.2 billion.

This report will not be updated.

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Most Recent Developments

The Consolidated Appropriations Act, 2008 (H.R. 2764), was passed by the House on December 17, 2007, and the Senate passed a measure the next day, December 18, with an amendment (McConnell Amendment—adding funding for the Iraq war). The House agreed to the McConnell Amendment on December 19. The bill was signed into law (P.L. 110-161) on December 26. The Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008 (MILCON-VA Appropriations Act), was included as Division I of P.L. 110-161. Under P.L. 110-161, the total amount of funding for the Veterans Health Administration (VHA) is \$37.2 billion; of this amount, \$2.6 billion was designated as contingent emergency funding and was available for obligation only after the President submitted a budget request to Congress. On January 17, 2008, the President transmitted a request to Congress designating \$2.6 billion as an emergency requirement in accordance with the provisions of P.L. 110-161.¹ **Table 1** provides funding levels for VA and VHA as included in the Consolidated Appropriations Act, 2008.²

Table 1. VA and VHA Appropriations, FY2006-FY2008

(\$ in thousands)

	FY2006 enacted	FY2007 enacted	FY2008 request	FY2008 House (H.R. 2642)	FY2008 Senate (H.R. 2642)	FY2008 enacted
Total Department of Veterans Affairs (VA)	\$71,457,832	\$79,550,522	\$83,903,751	\$87,696,839	\$87,501,280	\$87,595,142
Total Veterans Health Administration (VHA)	\$29,340,517	\$34,024,013	\$34,612,671	\$37,122,000	\$37,213,220	\$37,201,220

Source: S.Rept. 109-286, H.Rept. 109-464, H.Rept. 110-186, S.Rept. 110-85, *Congressional Record*, vol. 153 (December 17, 2007), pp. H16249-H16431.

Background

The Department of Veterans Affairs (VA) provides a range of benefits and services to veterans who meet certain eligibility rules, including disability compensation and pensions, education, training and rehabilitation services, hospital and medical care, assistance to homeless veterans,³ home loan guarantees, and death benefits that cover burial expenses.⁴ The VA carries out its programs nationwide through three administrations and the board of veterans appeals (BVA). The Veterans Health Administration (VHA) is responsible for health-care services and medical

¹ See http://www.whitehouse.gov/omb/budget/amendments/supplemental_1_17_08.pdf, last accessed on January 18, 2008.

² For detailed information on funding for the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA), see CRS Report RL34038, *Military Construction, Veterans Affairs, and Related Agencies: FY2008 Appropriations*, by Daniel H. Else, Christine Scott, and Sidath Viranga Panangala.

³ For detailed information on homeless veterans programs, see CRS Report RL34024, *Veterans and Homelessness*, by Libby Perl.

⁴ For a detailed description on eligibility for veterans disability benefits programs, see CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Programs*, by Douglas Reid Weimer.

research programs.⁵ The Veterans Benefits Administration (VBA) is responsible, among other things, for providing compensations, pensions, and education assistance.⁶ The National Cemetery Administration (NCA)⁷ is responsible for maintaining national veterans cemeteries; providing grants to states for establishing, expanding, or improving state veterans cemeteries; and providing headstones and markers for the graves of eligible persons, among other things.

The VA's budget includes both mandatory and discretionary spending accounts. Mandatory funding supports disability compensation, pension benefits, vocational rehabilitation, and life insurance, among other benefits and services. Discretionary funding supports a broad array of benefits and services, including medical care. In FY2007, discretionary budget authority accounted for about 48.1% of the total VA budget authority of approximately \$80 billion, with about 90% of this discretionary funding going toward supporting VA health-care programs.

The VHA operates the nation's largest integrated direct health-care delivery system.⁸ The VA's health-care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). Although policies and guidelines are developed at VA headquarters to be applied throughout the VA health-care system, management authority for basic decision making and budgetary responsibilities are delegated to the VISNs.⁹ Congressionally appropriated medical care funds are allocated to the VISNs based on the Veterans Equitable Resource Allocation (VERA) system, which generally bases funding on patient workload.¹⁰ Prior to the implementation of the VERA system, resources were allocated to facilities primarily on the basis of their historical expenditures. Unlike other federally funded health insurance programs, such as Medicare and Medicaid, which finance medical care provided through the private sector, the VHA provides care directly to veterans.

In FY2007, the VHA operated 155 medical centers, 135 nursing homes,¹¹ 717 ambulatory care and community-based outpatient clinics (CBOCs),¹² and 209 Readjustment Counseling Centers (Vet Centers).¹³ The VHA also pays for care provided to veterans by private-sector providers on a

⁵ For a detailed description of veterans' health-care issues, see CRS Report RL33993, *Veterans' Health Care Issues*, by Sidath Viranga Panangala.

⁶ For a detailed description of veterans' benefits issues, see CRS Report RL33985, *Veterans' Benefits: Issues in the 110th Congress*, coordinated by Carol D. Davis.

⁷ Established by the National Cemeteries Act of 1973 (P.L. 93-43).

⁸ Established on January 3, 1946, as the Department of Medicine and Surgery by P.L. 79-293, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration in 1991.

⁹ Jian Gao, Ying Wang and Joseph Engelhardt, "Logistic Analysis of Veterans' Eligibility-Status Change," *Health Services Management Research*, vol. 18, (August 2005), p. 175.

¹⁰ About 90% of the VHA appropriation is allocated through VERA. Networks also receive appropriated funds not allocated through VERA for such things as prosthetics, homeless programs, readjustment counseling, and clinical training programs. VA facilities could also retain collections from insurance reimbursements and copayments, and use these funds for the care of veterans.

¹¹ Data on the number of hospitals and nursing homes include facilities damaged by Hurricane Katrina. The data are current as of December 1, 2006.

¹² Data on the number of CBOCs differ from source to source. Some count clinics located at VA hospitals, whereas others count only freestanding CBOCs. The number represented in this report excludes clinics located in VA hospitals. The VA plans to activate 38 new CBOCs in FY2007 and FY2008.

¹³ On February 7, 2007, the Department announced that it will be establishing 23 new Vet Centers in communities across the nation during 2007 and 2008. New Vet Centers will be located in Montgomery, Alabama; Fayetteville, Arkansas; Modesto, California; Grand Junction, Colorado; Orlando, Fort Myers, and Gainesville, Florida; Macon, Georgia; Manhattan, Kansas; Baton Rouge, Louisiana; Cape Cod, Massachusetts; Saginaw and Iron Mountain, Michigan; Berlin, New Hampshire; Las Cruces, New Mexico; Binghamton, Middletown, Nassau County, and Watertown, New York; Toledo, Ohio; Du Bois, Pennsylvania; Killeen, Texas; and Everett, Washington. During 2007,

fee basis under certain circumstances. Inpatient and outpatient care is also provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).¹⁴ In addition, the VHA provides grants for construction of state-owned nursing homes and domiciliary facilities, and collaborates with the Department of Defense (DOD) in sharing health-care resources and services.

During FY2007, the VHA had an estimated total enrolled veteran population of 7.9 million and provided medical care to about 5.2 million unique veteran patients (see **Tables 2** and **3**). According to VHA estimates, the number of unique veteran patients is estimated to increase by approximately 110,000, from 5.2 million in FY2007 to 5.3 million in FY2008. As shown in **Table 3**, there would be a 2.4% increase in the total number of unique patients (both veterans and non-veterans), from 5.7 million in FY2007 to 5.8 million in FY2008.

Table 2. Number of Veterans Enrolled in the VA Health-Care System

Priority Groups	FY2006 Actual	FY2007 Estimate	FY2008 Estimate
1	912,787	915,068	917,349
2	522,829	524,135	525,442
3	996,063	998,552	1,001,041
4	241,716	242,320	242,924
5	2,538,228	2,544,571	2,550,913
6	265,253	265,916	266,579
<i>Subtotal Priority Groups 1-6</i>	<i>5,476,876</i>	<i>5,490,562</i>	<i>5,504,248</i>
7	218,248	218,793	219,339
8	2,177,314	2,182,755	2,188,194
<i>Subtotal Priority Groups 7-8</i>	<i>2,395,562</i>	<i>2,401,548</i>	<i>2,407,533</i>
Total Enrollees	7,872,438	7,892,110	7,911,781

Source: Department of Veterans Affairs.

The total number of outpatient visits, including visits to Vet Centers, reached 60.2 million during FY2006 and is projected to increase to 64.4 million in FY2007 and 67.4 million in FY2008.¹⁵ In FY2007, the VHA estimates that it will spend approximately 64.8% of its medical services obligations on outpatient care.¹⁶

the VA plans to open facilities in Grand Junction, Orlando, Cape Cod, Iron Mountain, Berlin, and Watertown. The other new Vet Centers are scheduled to open in 2008.

¹⁴ For further information on CHAMPVA, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Sidath Viranga Panangala and Susan Janeczko.

¹⁵ This number excludes outpatient care provided on a contract basis and outpatient visits to readjustment counseling centers. U.S. Department of Veterans Affairs, *FY2008 Congressional Budget Submissions, Medical Programs*, vol. 1 of 4, pp. 3-12.

¹⁶ Ibid., pp. 3-15.

Table 3. Number of Patients Receiving Care from the VA

Priority Groups	FY2006 Actual	FY2007 Estimate	FY2008 Estimate
1	768,537	718,452	717,262
2	342,023	349,751	356,566
3	568,740	600,337	618,513
4	177,563	198,922	207,535
5	1,645,781	1,850,707	1,933,212
6	134,425	121,664	131,785
Subtotal Priority Groups 1-6	3,637,069	3,839,833	3,964,873
7	197,901	339,021	345,561
8	1,195,612	1,003,223	981,327
Subtotal Priority Groups 7-8	1,393,513	1,342,244	1,326,888
Subtotal Unique Veteran Patients ^a	5,030,582	5,182,077	5,291,761
Non-veterans ^b	435,488	503,069	527,415
Total Unique Patients	5,466,070	5,685,146	5,819,176

Source: Department of Veterans Affairs.

- a. Unique veteran patients include Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans. These patients number 155,272 in FY2006; estimated to be 209,308 in FY2007 and 263,345 in FY2008.
- b. Non-veterans include CHAMPVA patients, reimbursable patients with VA-affiliated hospitals and clinics, care provided on a humanitarian basis, and employees receiving preventive occupational immunizations.

Eligibility for Veterans' Health Care

"Promise of Free Health Care"

To understand some of the issues discussed later in this report, it is important to understand eligibility for VA health care, the VA's enrollment process, and its enrollment priority groups. Unlike Medicare or Medicaid, VA health care is not an entitlement program. Contrary to numerous claims made concerning "promises" to military personnel and veterans with regard to "free health care for life," not every veteran is automatically entitled to medical care from the VA.¹⁷ Prior to eligibility reform in 1996, provisions of law governing eligibility for VA care were complex and not uniform across all levels of care. All veterans were technically "eligible" for hospital care and nursing home care, but eligibility did not by itself ensure access to care.

The Veterans' Health Care Eligibility Reform Act of 1996, P.L. 104-262, established two eligibility categories and required the VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.¹⁸ P.L. 104-262 authorized the VA to provide all needed hospital care and medical services to veterans with service-

¹⁷ For a detailed discussion of "promised benefits," see CRS Report 98-1006, *Military Health Care: The Issue of "Promised" Benefits*, by David F. Burrelli.

¹⁸ U.S. Congress, House Committee on Veterans Affairs, *Veterans' Health Care Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong. 2nd sess., H.Rept. 104-690 p. 2.

connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards such as Agent Orange, veterans whose attributable income and net worth are not greater than an established “means test,” and veterans of World War I. These veterans are generally known as “higher priority” or “core” veterans (see **Appendix A**, discussed in more detail below).¹⁹ The other category of veterans are those with no service-connected disabilities and with attributable incomes above an established means test (see **Appendix C**).

P.L. 104-262 also authorized the VA to establish a patient enrollment system to manage access to VA health care. As stated in the report language accompanying P.L. 104-262, “the Act would direct the Secretary, in providing for the care of ‘core’ veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate.”²⁰

Furthermore, P.L. 104-262 was clear in its intent that the provision of health care to veterans was dependent upon the available resources. The committee report accompanying P.L. 104-262 states that the provision of hospital care and medical services would be provided to “the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations.”²¹

VHA Health-Care Enrollment

As stated previously, P.L. 104-262 required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The new eligibility standard was created by Congress to “ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished.”²²

For most veterans, entry into the veterans’ health-care system begins by completing the application for enrollment. Some veterans are exempt from the enrollment requirement if they meet special eligibility requirements.²³ A veteran may apply for enrollment by completing the Application for Health Benefits (VA Form 10-10EZ) at any time during the year and submitting the form online or in person at any VA medical center or clinic, or mailing or faxing the completed form to the medical center or clinic of the veteran’s choosing.²⁴ Once a veteran is enrolled in the VA health-care system, the veteran remains in the system and does not have to reapply for enrollment annually. However, those veterans who have been enrolled in Priority Group 5 (see **Appendix A**, discussed in more detail below) based on income must submit a new

¹⁹ Ibid., p.5.

²⁰ Ibid., p.6.

²¹ Ibid., p.5.

²² Ibid., p.4.

²³ Veterans do not need to apply for enrollment in the VA’s health-care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentage ratings represent the average impairment in earning capacity resulting from diseases and injuries encountered as a result of or incident to military service; those with a rating of 50% or more are placed in Priority Group 1); less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from the VA only for a service-connected disability (even if the rating is only 10%).

²⁴ VA Form 10-10EZ is available at <https://www.1010ez.med.va.gov/sec/vha/1010ez/#Process>.

VA Form 10-10EZ annually with updated financial information demonstrating inability to defray the expenses of necessary care.²⁵

Veteran's Status

Eligibility for VA health care is based primarily on “veteran’s status” resulting from military service. Veteran’s status is established by active-duty status in the military, naval, or air service and an honorable discharge or release from active military service. Generally, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health-care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. Also, reservists that were called to active duty and who completed the term for which they were called, and who were granted an other than dishonorable discharge, are exempt from the 24 continuous months of active duty requirement. National Guard members who were called to active duty by federal executive order are also exempt from this two-year requirement if they (1) completed the term for which they were called and (2) were granted an other than dishonorable discharge.

When not activated to full-time federal service, members of the reserve components and National Guard have limited eligibility for VA health-care services. Members of the reserve components may be granted service-connection for any injury they incurred or aggravated in the line of duty while attending inactive duty training assemblies, annual training, active duty for training, or while going directly to or returning directly from such duty. In addition, reserve component service members may be granted service-connection for a heart attack or stroke if such an event occurs during these same periods. The granting of service-connection makes them eligible to receive care from the VA for those conditions. National Guard members are not granted service-connection for any injury, heart attack, or stroke that occurs while performing duty ordered by a governor for state emergencies or activities.²⁶

After veteran’s status has been established, the VA next places applicants into one of two categories. The first group is composed of veterans with service-connected disabilities or with incomes below an established means test. These veterans are regarded by the VA as “high priority” veterans, and they are enrolled in Priority Groups 1-6 (see **Appendix A**). Veterans enrolled in Priority Groups 1-6 include

- veterans in need of care for a service-connected disability;²⁷
- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval, or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war (POWs);
- veterans awarded the Purple Heart;
- veterans who have been determined by VA to be catastrophically disabled;
- veterans of World War I;

²⁵ 38 C.F.R. §17.36 (d)(3)(iv) (2005).

²⁶ 38 U.S.C. §101(24); 38 C.F.R. §3.6(c).

²⁷ The term “service-connected” means, with respect to disability, that such disability was incurred or aggravated in line of duty in the active military, naval, or air service. The VA determines whether veterans have service-connected disabilities and, for those with such disabilities, assigns ratings from 0 to 100% based on the severity of the disability. Percentages are assigned in increments of 10%.

- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have an annual income and net worth below a VA-established means test threshold.

The VA looks at applicants' income and net worth to determine their specific priority category and whether they have to pay co-payments for nonservice-connected care. In addition, veterans are asked to provide the VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. The VA may bill these payers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. **Appendix B** provides information on what categories of veterans pay for which services.

The second group of veterans is composed of those who do not fall into one of the first six priority groups—primarily veterans with nonservice-connected medical conditions and with incomes and net worth above the VA-established means test threshold. These veterans are enrolled in Priority Group 7 or 8.²⁸ **Appendix C** provides information on income thresholds for VA health-care benefits.

Priority Groups and Scheduling Appointments

The VHA is mandated to provide priority care for non-emergency outpatient medical care for *any* condition of a service-connected veteran rated 50% or more, or for a veteran's service-connected condition.²⁹ According to VHA policies, patients with emergency or urgent medical needs must be provided care, or must be scheduled to receive care as soon as practicable, independent of service-connected status and whether care is purchased or provided directly by the VA. Veterans who are service-connected 50% or more need to be scheduled to be seen within 30 days of the desired date for any condition.

Veterans who are rated less than 50% service-connected disabled, and who require care for a service-connected condition, need to be scheduled to be seen within 30 days of the desired date. When VHA staff are in doubt as to whether the request for care is for a service-connected condition, they are required to assume, on behalf of the veteran, that the veteran is entitled to priority access and schedule within 30 days of the desired date.³⁰

Veterans in other priority groups are to be scheduled to be seen within 120 days of the desired date. According to VHA policies, all outpatient appointment requests must be acted on as soon as possible, but no later than seven calendar days from the date of the request. The VHA also requires that priority scheduling of any veteran must not affect the medical care of any other previously scheduled veteran. Furthermore, VHA guidelines state that veterans with service-connected conditions cannot be prioritized over other veterans with more acute health-care needs.³¹

²⁸ The VA considers a veteran's previous year's total household income (both earned and unearned income, as well as his/her spouse's and dependent children's income). Earned income is usually wages received from working. Unearned income includes interest earned, dividends received, money from retirement funds, Social Security payments, annuities, and earnings from other assets. The number of persons in the veterans family will be factored into the calculation to determine the applicable income threshold. 38 C.F.R. § 17.36(b)(7) (2006).

²⁹ VHA Directive 2006-055, October 11, 2006.

³⁰ Ibid.

³¹ Ibid.

Funding for the VHA

The VHA is funded through multiple appropriations accounts that are supplemented by other sources of revenue. Although the appropriations account structure has been subject to change from year to year, the appropriation accounts used to support the VHA traditionally include medical care, medical and prosthetic research, and medical administration. In addition, Congress also appropriates funds for construction of medical facilities through a larger appropriations account for construction for all VA facilities. In FY2004, “to provide better oversight and [to] receive a more accurate accounting of funds,” Congress changed the VHA’s appropriations structure.³² The Department of Veterans Affairs and Housing and Urban Development and Independent Agencies Appropriations Act, 2004 (P.L. 108-199, H.Rept. 108-401), funded VHA through four accounts: (1) medical services, (2) medical administration, (3) medical facilities, and (4) medical and prosthetic research. Provided below are brief descriptions of these accounts.

Medical Services

The medical services account covers expenses for furnishing inpatient and outpatient care and treatment of veterans and certain dependents, including care and treatment in non-VA facilities; outpatient care on a fee basis; medical supplies and equipment; salaries and expenses of employees hired under Title 38, United States Code; and aid to state veterans homes. In its FY2008 budget request to Congress, the VA requested the transfer of food service operations costs from the medical facilities appropriations to the medical services appropriations. The House and Senate Appropriations Committees have concurred with this request.³³

Medical Administration

The medical administration account provides funds for the expenses in the administration of hospitals, nursing homes, and domiciliaries; billing and coding activities; quality of care oversight; legal services; and procurement.

Medical Facilities

The medical facilities account covers, among other things, expenses for the maintenance and operation of VHA facilities; administrative expenses related to planning, design, project management, real property acquisition and disposition, construction, and renovation of any VHA facility; leases of facilities; and laundry services.

Medical and Prosthetic Research

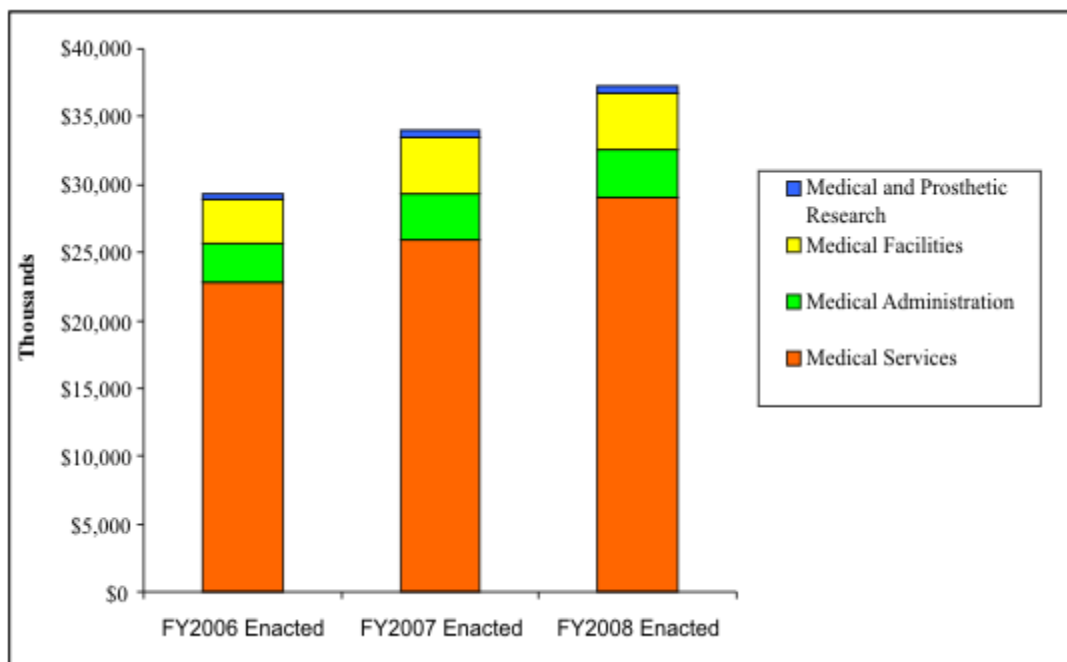
This account provides funding for VA researchers to investigate a broad array of veteran-centric health topics, such as treatment of mental health conditions, rehabilitation of veterans with limb loss, traumatic brain injury and spinal cord injury, organ transplantation, and the organization of the health-care delivery system. VA researchers receive funding not only through this account but also from the DOD, the National Institutes of Health (NIH), and private sources.

³² U.S. Congress, Conference Committees, *Consolidated Appropriations Act, 2004*, conference report to accompany H.R. 2673, 108th Cong., 1st sess., H.Rept. 108-401, p. 1036.

³³ The cost of food service operations support hospital food service workers, provisions, and supplies related to the direct care of patients.

As seen in **Figure 1**, the total level of funding for VHA increased between FY2006 and FY2008, and most of this increase has been due to the increase in spending on medical services. As a percentage of total VHA funding, spending on medical facilities, medical administration, and medical and prosthetic research has been fairly stable.

Figure 1. VHA Funding, FY2006-FY2008



Source: Chart prepared by CRS based on H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H.Rept. 109-359; H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; *Congressional Record*, vol. 153, May 24, 2007, H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153, (September 7, 2007), SI 1271-SI 1278; and *Congressional Record*, vol. 153 (December 17, 2007), pp. H16249-H16431.

Medical Care Collections Fund (MCCF)

In addition to direct appropriations for the above accounts, the Committees on Appropriations include medical care cost recovery collections when considering the amount of resources needed to provide funding for the VHA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986, gave the VHA the authority to bill some veterans and most health-care insurers for nonservice-connected care provided to veterans enrolled in the VA health-care system, to help defray the cost of delivering medical services to veterans.³⁴

The Balanced Budget Act of 1997 (P.L. 105-33) gave the VHA the authority to retain these funds in the Medical Care Collections Fund (MCCF). Instead of returning the funds to the Treasury, the VA can use them for medical services for veterans without fiscal year limitations.³⁵ To increase the VA's third-party collections, P.L. 105-33 also gave the VA the authority to change its basis of

³⁴ Veterans' Health-Care and Compensation Rate Amendments of 1985, 100 Stat. 372, 373, 383.

³⁵ For a detailed history of funding for VHA from FY1995 to FY2004, see CRS Report RL32732, *Veterans' Medical Care Funding: FY1995-FY2004*, by Sidath Viranga Panangala.

billing insurers from “reasonable costs” to “reasonable charges.”³⁶ This change in billing was intended to enhance VA collections to the extent that reasonable charges result in higher payments than reasonable costs.³⁷ In FY2004, the Administration’s budget requested consolidating several medical existing collections accounts into one MCCF. The conferees of the Consolidated Appropriations Act of 2004 (H.Rept. 108-401) recommended that collections that would otherwise be deposited in the Health Services Improvement Fund (former name), Veterans Extended Care Revolving Fund (former name), Special Therapeutic and Rehabilitation Activities Fund (former name), Medical Facilities Revolving Fund (former name), and the Parking Revolving Fund (former name) should be deposited in MCCF.³⁸ The Consolidated Appropriations Act of 2005, (P.L. 108-447, H.Rept. 108-792) provided the VA with permanent authority to deposit funds from these five accounts into the MCCF. The funds deposited into the MCCF would be available for medical services for veterans. These collected funds do not have to be spent in any particular fiscal year and are available until expended.

The conferees of the FY2006 Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act (P.L. 109-114, H.Rept. 109-305), required the VA to establish a revenue improvement demonstration project. The purpose of this pilot project is to provide a “comprehensive restructuring of the complete revenue cycle including cash-flow management and accounts receivable.”³⁹ The conferees included this provision because the Appropriation Committees were concerned that the VHA was collecting only 41% percent of the billed amounts from third-party insurance companies. Currently, the VHA has established a pilot Consolidated Patient Account Center in VISN 6.

As shown in **Table 4**, MCCF collections increased by 31%, from \$1.5 billion in FY2003 to \$2.0 billion in FY2006. During this same period, first-party collections increased by 26%, from \$685 million to \$863 million. In FY2006, first-party collections represented approximately 43% of total MCCF collections.

Table 4. Medical Care Collections, FY2003-FY2006

(\$ in thousands)

	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual
First-party pharmacy co-payments ^a	\$576,554	\$623,215	\$648,204	\$723,027
First-party co-payments for inpatient and outpatient care	104,994	113,878	118,626	135,575
First-party long-term care co-payments ^b	3,461	5,077	5,411	4,347
Third-party insurance collections	804,141	960,176	1,055,597	1,095,810
Enhanced use leasing revenue ^c	234	459	26,861	3,379
Compensated work therapy collections ^d	38,834	40,488	36,516	40,081

³⁶ Under “reasonable costs,” the VA billed insurers based on its average cost to provide a particular episode of care. Under “reasonable charges,” the VA bills insurers based on market pricing for health-care services.

³⁷ U.S. Government Accountability Office (GAO), *VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain*, GAO/HEHS-99-124, June 1999.

³⁸ For a detailed description of these former accounts, see CRS Report RL32548, *Veterans’ Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala.

³⁹ U.S. Congress, Conference Committees, *Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act, 2006*, conference report to accompany H.R. 2528, 109th Congress, 1st session, H.Rept. 109-305, p. 43.

	FY2003 Actual	FY2004 Actual	FY2005 Actual	FY2006 Actual
Parking fees ^e	3,296	3,349	3,443	3,083
Compensation and pension living expenses ^f	376	634	2,431	2,075
MCCF Total	\$1,531,890	\$1,747,276	\$1,897,089	\$2,007,377

Sources: Table prepared by CRS based on data provided by the Department of Veterans Affairs, and U.S. Department of Veterans Affairs, *FY2008 Congressional Budget Submissions, Medical Programs*, vol. 1 of 4, pp. 3-8.

Notes: The following accounts were not consolidated into the MCCF until FY2004: enhanced use leasing revenue, compensated work therapy collections, parking fees, and compensation and pension living expenses. Collection figures for these accounts for FY2003 are provided for comparison purposes.

- a. In FY2002, Congress created the Health Services Improvement Fund (HSIF) to collect increases in pharmacy co-payments (from \$2 to \$7 for a 30-day supply of outpatient medication) that went into effect on February 4, 2002. The Consolidated Appropriations Resolution, 2003 (P.L. 108-7) granted the VA the authority to consolidate the HSIF with the MCCF and granted permanent authority to recover co-payments for outpatient medications.
- b. Authority to collect long-term care co-payments was established by the Millennium Health Care and Benefits Act (P.L. 106-117). Certain veteran patients receiving extended care services from VA providers or outside contractors are charged co-payments.
- c. Under the enhanced-use lease authority, the VA may lease land or buildings to the private sector for up to 75 years. In return the VA receives fair consideration in cash and/or in-kind. Funds received as monetary considerations may be used to provide care for veterans.
- d. The compensated work therapy program is a comprehensive rehabilitation program that prepares veterans for competitive employment and independent living. As part of their work therapy, veterans produce items for sale or undertake subcontracts to provide certain products and/or services, such as providing temporary staffing to a private firm. Funds collected from the sale of these products and/or services are deposited into the MCCF.
- e. The Parking program provides funds for construction and acquisition of parking garages at VA medical facilities. The VA collects fees for use of these parking facilities.
- f. Under the compensation and pension living expenses program, veterans who do not have either a spouse or child would have their monthly pension reduced to \$90 after the third month a veteran is admitted for nursing home care. The difference between the veteran's pension and the \$90 is used for the operation of the VA medical facility.

FY2007 Budget Summary⁴⁰

On February 6, 2006, the President submitted his FY2007 budget proposal to Congress. The Administration requested \$32.7 billion for the VHA, an 11.3% increase over the FY2006 enacted amount of \$29.3 billion and a 10% increase over FY2005 enacted amount of \$29.7 billion (see **Table 5** and **Appendix D**). The FY2007 request included \$25.5 billion for medical services, a 12% increase over the FY2006 enacted amount; \$3.2 billion for medical administration, an 11.2% increase over FY2006; \$3.6 billion for medical facilities, an 8.2% increase over FY2006; and \$399 million for medical and prosthetic research, a 3.2% decrease from the FY2006 enacted amount. (For a detailed breakdown of funding levels for the VHA for FY2005 and FY2006, see **Appendix D**).

⁴⁰ For a detailed description of VA Medical Care Appropriations for FY2007, see CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

House Action

On May 19, 2006, the House passed its version of the Military Construction, Military Quality of Life, and Veterans Affairs Appropriations bill (MIL-CON-QUAL-appropriations bill) for FY2007 (H.R. 5385, H.Rept. 109-464). H.R. 5385 provided \$32.7 billion for the VHA, a \$3.4 billion (11.4%) increase over the FY2006 enacted amount of \$29.3 billion and about the same as the President's request. This amount included \$25.4 billion for medical services, \$100 million less than the President's request and \$2.6 billion (11.6%) over the FY2006 enacted amount of \$22.8 billion. The MIL-CON-QUAL-appropriations bill for FY2007 also provided \$3.3 billion for medical administration, \$100 million above the Administration's request of \$3.2 billion, and \$3.6 billion for medical facilities, \$25 million above the budget request. H.R. 5385 also provided \$412 million for medical and prosthetic research, a 3.2% increase over the President's request of \$399 million (see **Table 5**).

Senate Action

On November 14, 2006, the Senate passed by voice vote its version of the Military Construction and Veterans Affairs, and Related Agencies Appropriations bill (MIL-CON-VA-appropriations bill) for FY2007 (H.R. 5385, S.Rept. 109-286). H.R. 5385, as amended by the Senate, provided \$32.7 billion for the Veterans Health Administration (VHA) for FY2007, about the same as the House-passed amount and the President's request. This amount included \$28.7 billion for medical services, a 26.0% increase over the FY2006 enacted amount, a 12.5% increase over the President's request, and a 13.0% increase over the House-passed amount. The Senate-passed version of H.R. 5385 also provided \$3.6 billion for medical facilities, which was the same as the Administration's request and \$25.0 million less than the House-passed amount, and \$412 million for medical and prosthetic research. This amount was the same as the House-passed amount and \$13.0 million above the President's request (see **Table 5**).

Continuing Appropriations Resolution

At the end of the 109th Congress, Congress did not pass the MIL-CON-VA-appropriations bill for FY2007, and funded most government agencies, including the VA, through a series of Continuing Appropriations Resolutions (P.L. 109-289, division B, as amended by P.L. 109-369 and P.L. 109-383). On January 31, 2007, the House passed the Revised Continuing Appropriations Resolution, 2007 (H.J.Res. 20), and the Senate passed it without amendment on February 14.⁴¹ On February 15, 2007, the President signed into law the Revised Continuing Appropriations Resolution, 2007 (H.J.Res. 20, P.L. 110-5). It provided \$32.7 billion for the VHA for FY2007, a \$14.7 million increase over the President's request and \$3.3 billion above the FY2006 enacted amount. This amount included \$25.5 billion for medical services, \$3.2 billion for medical administration, \$3.6 billion for medical facilities, and \$414 million for medical and prosthetic research. These amounts were the same as the President's request, except for the medical and prosthetic research account, which was \$15 million above the President's request. The Revised Continuing Appropriations Resolution *did not* include any provisions that would have given the VA the authority to implement fee increases as requested by the Administration's budget proposal for the VHA for FY2007.

⁴¹ To calculate the total funding level remaining for the VA in FY2007, the Department would subtract the funding provided in the previously enacted FY2007 Continuing Resolutions from the amount provided in P.L. 110-5.

FY2007 Supplemental Appropriations

On May 24, 2007, the House and Senate approved the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (H.R. 2206). The bill was signed into law on May 25 (P.L. 110-28). Among other things, P.L. 110-28 provided a total of \$1.34 billion for the VHA for FY2007. This amount was in addition to the amount appropriated under P.L. 110-5. This amount included \$400 million for medical services:⁴² (1) \$9.4 million for polytrauma residential transition rehabilitation programs; (2) \$10 million for additional transition caseworkers; (3) \$20 million for substance abuse treatment programs; (4) \$20 million for readjustment counseling (Vet Centers); (5) \$10 million for blind rehabilitation services; (6) \$100 million for enhancement of mental health services; (7) \$8 million for polytrauma support clinic teams; (8) \$5.4 million for additional polytrauma points of contact; (9) \$193 million for treatment of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans; and (10) \$25 million for prosthetics.

P.L. 110-28 also provided \$326 million for the Construction, Minor Projects account, with specific funding of \$36.0 million for construction costs related to establishing polytrauma residential transitional rehabilitation programs.⁴³ It also provided \$250 million for medical administration and \$595 million for medical facilities, including specific funding of (1) \$45.0 million for facility and equipment upgrades at polytrauma centers and (2) \$550 million for non-recurring maintenance to address structural deficiencies in VA medical facilities.⁴⁴

FY2008 VHA Budget

On February 5, 2007, the President submitted his FY2008 budget proposal to Congress. The total amount requested by the Administration for the VHA for FY2008 was \$34.6 billion, a 1.93% increase in funding compared with the FY2007 enacted amount. The total amount of funding that would have been available for the VHA under the President's budget proposal for FY2008, including collections, was approximately \$37.0 billion (see **Table 5**). For FY2008, the Administration requested \$27.2 billion for medical services, a \$1.2 billion, or 4.8%, increase in funding over the FY2007 enacted amount. The Administration's budget proposal also requested \$3.4 billion for medical administration, \$3.6 billion for medical facilities, and \$411 million for medical and prosthetic research (see **Table 5**). As in FY2003, FY2004, FY2005, FY2006, and FY2007, the Administration included several cost-sharing proposals. These legislative proposals are discussed in detail in the "Key Budget Issues" section at the end of this report.

FY2008 Congressional Budget Resolution

On May 17, 2007, the House and Senate adopted the Conference Report (H.Rept. 110-153) to accompany the Concurrent Resolution on the Budget for FY2008 (S.Con.Res. 21). The conference agreement provided a total of \$85.3 billion in budget authority for all veterans benefits and services for FY2008, and a total of \$452.8 billion in budget authority for FY2008-FY2012. Of the amount allocated for FY2008, the conference agreement provided \$43.1 billion for discretionary veterans' programs, which consists mainly of VA medical care. Furthermore, the

⁴² The initial amount enacted was \$466.7 million. P.L. 110-161 (H.R. 2764) transferred \$66 million from the FY2007 medical services account to the construction, major projects account for FY2007 to fund a new Level I polytrauma center to be located in San Antonio, Texas.

⁴³ Conference Report published in *Congressional Record*, vol. 153, part II (May 24, 2007), pp. H5776-H5910.

⁴⁴ A list of structural deficiencies identified by the VA can be found at http://www1.va.gov/opa/pressrel/docs/Environment_of_Care_Roll-up.pdf.

conference agreement rejected the veterans' health-care enrollment fees and co-payment increases that were proposed by the President's budget request.

House Action

On May 22, 2007, the House Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, approved by voice vote a draft measure recommending funding levels for FY2008 for military construction programs, the VA, and related agencies. On June 6, the full House Appropriations Committee recommended \$37.1 billion for the VHA for FY2008, a 9.3% increase over the FY2007 enacted amount of \$34.0 billion and 7.3% above the President's request. This amount included \$28.9 billion for medical services, \$1.9 billion (6.9%) above than the President's request and \$2.9 billion (12.0%) over the FY2007 enacted amount of \$26.0 billion. Of the amount recommended for the medical services account, the committee included bill language stipulating \$2.9 billion for speciality mental health care, \$130 million for the homeless veterans grant and per diem program, \$429 million for the substance abuse program, and \$100 million for blind rehabilitation services.

The committee recommendation also included \$3.6 billion for medical administration, \$193 million above the Administration's request of \$3.4 billion; \$4.1 billion for medical facilities, a 14% increase over the President's request; and \$480 million for medical and prosthetic research, a 17% increase over the President's request of \$411 million (see **Table 5**). The committee *did not* recommend any fee increases as requested by the Administration's budget proposal for the VHA for FY2008. The Military Construction and Veterans Affairs appropriations bill for FY2008 (H.R. 2642, H.Rept. 110-186) was reported out of committee on June 11.

On June 15, 2007, the House passed H.R. 2642. As amended, H.R. 2642 provided \$29.0 billion for medical services. This included the transfer of \$125 million from the medical administration account to the medical services account. The reason for this transfer was because during House floor debate, Representative Shelley Moore Capito offered an amendment to transfer \$5 million to the medical services account for the establishment of an Office of Rural Health within the Office of the Under Secretary for Health, as directed by P.L. 109-461. Representative Jerry Moran also offered an amendment to transfer \$120 million to the medical services account to increase funding for the Veterans Beneficiary Travel Program.

The MILCON-VA appropriations bill, as amended, also provided \$3.5 billion for the medical administration account, \$68.6 million above the FY2008 request and \$82.6 million above the FY2007 enacted amount. All other amounts for the VHA were equal to the committee-recommended funding levels.

Construction Projects

H.R. 2642 has provided approximately \$2.2 billion for VA construction projects (excluding grants for construction of state veterans cemeteries), including funding for Capital Asset Realignment for Enhanced Services (CARES) projects (see **Table 6**).⁴⁵ A large portion of this amount was for construction and building improvements of VA medical facilities. The House Appropriations Committee did not recommended any funding amounts for various construction and projects submitted by Members of Congress or by the Administration. According to H.Rept. 110-186,

⁴⁵ For a detailed description of the Capital Asset Realignment for Enhanced Services (CARES) program, see CRS Report RL33993, *Veterans' Health Care Issues*, by Sidath Viranga Panangala.

“individual project allocations will be considered comprehensively after the Committee has properly analyzed all relevant information.”⁴⁶

Senate Action

On June 13, 2007, the Senate Appropriations Committee, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, approved a draft version of the MILCON-VA appropriations bill. On June 14, the full Senate Appropriations Committee approved the measure. The bill was reported to the Senate on June 18 (S. 1645, S.Rept. 110-85). S. 1645, as reported, provided a total of \$37.2 billion for the VHA. This amount includes \$29.0 billion for medical services, a \$3 billion (11.5%) increase over the FY2007 enacted amount and \$1.8 billion over the FY2008 budget request, and \$3.6 billion for medical administration, \$214 million (6.2%) above the FY2007 enacted amount and \$200 million above the FY2008 Administration's request. Furthermore, the Senate version of the MILCON-VA appropriations bill, as reported, provided \$4.1 billion for medical facilities—a 14.0% increase over the FY2008 request and 1.7% less than the FY2007 enacted amount—and \$500 million for medical and prosthetic research—a 12% increase over the FY2007 enacted amount, a 22.0% increase over the FY2008 request, and 4.2% above the House-passed amount. The committee *did not* recommend any fee increases as requested by the Administration's budget proposal for the VHA for FY2008.

On September 6, 2007, the Senate passed H.R. 2642 with an amendment to reflect the Senate Appropriations Committee-approved measure (S. 1645, S.Rept. 110-85). During Senate floor debate, an amendment offered by Senator Jon Tester was approved to transfer \$125 million from the medical administration account to the medical services account. This additional amount of funding would have been available for the Veterans Beneficiary Travel Program. With this transfer of funds, \$29.1 billion would have been available for medical services—a \$3.2 billion (12.3%) increase over the FY2007 enacted amount and \$1.9 billion over the FY2008 budget request—and \$3.5 billion would have been available for medical administration, \$75 million above the FY2008 Administration's request (**Table 5**). All other amounts for the VHA were equal to the committee-recommended funding levels.

Construction Projects

H.R. 2642, as amended by the Senate, provided a total of \$1.7 billion for VA construction projects (**Table 6**).⁴⁷ Unlike the House Appropriations Committee, the Senate Appropriations Committee provided funding for specific construction projects requested by the President. However, the committee continued the practice of not earmarking major construction projects that are not requested in the President's budget proposal.

Consolidated Appropriations Act for FY2008

At the end of 2007, Congress passed the Consolidated Appropriations Act for FY2008 (H.R. 2764), an omnibus measure that combined the 11 outstanding appropriations bills for FY2008.⁴⁸ H.R. 2764 was passed by the House on December 17, 2007; the Senate passed the measure the

⁴⁶ U.S. Congress, House Committee on Appropriations, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2008*, report to accompany H.R. 2642, 110th Congress, 1st session, H.Rept. 110-186, p. 51.

⁴⁷ This amounts excludes grants for construction of state veterans cemeteries, which are funded under a separate account.

⁴⁸ The only appropriations bill that passed as a stand alone measure was the Department of Defense Appropriations Act, 2008 (H.Rept. 110-434), which was signed into law on November 13 (P.L. 110-116).

next day, December 18, with an amendment (McConnell Amendment—adding funding for the Iraq war). The House agreed to the McConnell Amendment on December 19. The bill was signed into law (P.L. 110-161) on December 26. Division I of H.R. 2764 included the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008 (MILCON-VA Appropriations Act).

The MILCON-VA Appropriation Act provided \$37.2 billion for VHA for FY2008, which is \$2.6 billion above the Administration's request for FY2008 (see **Table 5**). Of this amount, \$2.6 billion (the amount above the Administration's request) was designated as contingent emergency funding and was to be available for obligation only after the President submitted a budget request to Congress. On January 17, 2008, the President submitted a budget request to Congress, requesting this additional amount and designating it as an emergency requirement. Of the total amount appropriated for VHA, \$29.1 billion has been allocated to the medical services account, which is almost \$2 billion above the President's FY2008 request. The amount appropriated for medical services includes

- an additional \$125 million to increase the beneficiary travel reimbursement mileage rate to 28.5 cents per mile,
- an additional \$70 million for substance abuse services,
- an additional \$12.5 million for expanded outpatient services for the blind, and
- an additional \$15 million for Vet Centers.⁴⁹

The explanatory statement (discussed below) also stipulates that of the total amount appropriated for medical services, not less than \$2.9 billion shall be expended for specialty mental health care, and not less than \$130 million shall be expended for the homeless grants and per diem program.

Construction Projects

P.L. 110-161 has appropriated approximately \$1.9 billion for VA construction projects, an \$818 million increase over the Administration's request. This increase in funding was provided to address insufficient funding levels in the advanced planning fund and to compensate for cost adjustments to previously appropriated major construction projects. The Consolidated Appropriations Act for FY2008 provided funding for specific VA construction projects as requested by the Administration.

Explanatory Statement

The explanatory statement accompanying the Consolidated Appropriations Act (H.R. 2764, P.L. 110-161) included several major areas of interest to the Appropriations Committees, and incorporated some report language from H.Rept. 110-186, and S.Rept. 110-85.

Joint Efforts Between DOD and VA

The Appropriation Committees have urged both DOD and VA to seek every opportunity to partner to improve the continuity of care for veterans through: joint clinics; joint Centers of Excellence for Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI); joint research and/or treatment; and the development of joint clinical practice guidelines for polytrauma injury, TBI, burns, and amputee care, among other things.

⁴⁹ *Congressional Record*, vol. 153 (December 17, 2007), pp. H16386.

Traumatic Brain Injury (TBI)

Currently, there is no medical diagnostic code specific to TBI, therefore, it is a challenge to quantify the number of TBI cases. Presently, both DOD and VA are working with the National Center for Health Statistics to refine current International Classification of Diseases-9th Revision (ICD—9) codes to better reflect the TBI patient population within both DOD and VA. Beginning with FY2009, the appropriators are directing the Administration to include TBI as a select program within the medical services account in order that committees might better account for special needs of these patients.

Mental Health and Substance Abuse

The Appropriation Committees expressed concern about insufficient funding levels for mental health and substance abuse services in the FY2008 budget request. The Administration's budget request had included a reduction in the number of inpatient beds for psychiatric care and an anticipated increase of less than one percent for substance abuse services. The Consolidated Appropriations Act (H.R. 2764, P.L. 110-161) includes increased funding within the medical services account in order to increase access to substance abuse services, and ensure that adequate inpatient psychiatric care is maintained. The appropriators also directed the VA to reexamine the policy for a reduction in psychiatric inpatient care, taking into account the needs of returning OIF and OEF veterans. Furthermore, the explanatory statement directs the VA not to reduce the number of inpatient psychiatric beds at any facility that currently has a waiting list.

Access to Medical Care in Remote Rural Areas

Veterans access to VA care in remote rural areas has been a long standing issue. To address this issue the appropriators have directed the VA to provide a report to the committees that includes a description of the unique challenges and costs faced by veterans in remote rural areas when obtaining medical services from the VA, and the need to improve access to locally administered care for veterans who reside in remote rural areas. The report should also identify the need to fund alternative sources of medical services in areas where VA medical facilities are not accessible to veterans without them leaving such areas. Moreover, the report should also contain an assessment of the potential for increasing local access to medical services for veterans in remote rural areas through strategic partnerships with other government and local private health care providers.

Electronic Medical Record

The explanatory statement accompanying the Consolidated Appropriations Act (H.R. 2764, P.L. 110-161) directs the DOD and VA to provide a joint report to the Committees on Appropriations detailing the actions being taken by each Department to achieve an interoperable electronic medical record (EMR) system. Furthermore, the report must identify all ongoing and planned projects and programs within both DOD and VA addressing interoperability. Similar language has been included in the Defense Appropriations conference report (H.Rept. 110-434).

Table 5.VHA Appropriations by Account, FY2006-FY2008

(\$ in thousands)

Program	FY2006 enacted	FY2007 request	FY2007 House	FY2007 Senate	FY2007 enacted	FY2008 request	FY2008 House (H.R. 2642)	FY2008 Senate (H.R. 2642)	FY2008 enacted
Medical services	\$21,322,141	\$25,512,000	\$25,412,000	\$28,689,000	\$25,518,254	\$27,167,671	\$29,031,400	\$29,104,220	\$27,167,671
Emergency appropriations	1,225,000	—	—	—	—	—	—	—	—
Emergency appropriations— Defense, the Global War on Terror, and Hurricane Recovery (P.L. 109-234)	198,265	—	—	—	—	—	—	—	—
Emergency appropriations— Avian Flu Pandemic (P.L. 109-148)	27,000	—	—	—	—	—	—	—	—
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability (P.L. 110-28)	—	—	414,982	454,131	400,778 ^a	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	—	—	—	1,936,549
<i>Subtotal medical services</i>	<i>22,772,406</i>	<i>25,512,000</i>	<i>25,826,982</i>	<i>29,143,131</i>	<i>25,919,032</i>	<i>27,167,671</i>	<i>29,031,400</i>	<i>29,104,220</i>	<i>29,104,220</i>
Medical administration	2,858,442	3,177,000	3,277,000	—	3,177,968	3,442,000	3,510,600	3,517,000	3,442,000
Emergency appropriations (P.L. 110-28)	—	—	256,300	250,000	250,000	—	—	—	—

Program	FY2006 enacted	FY2007 request	FY2007 House	FY2007 Senate	FY2007 enacted	FY2008 request	FY2008 House (H.R. 2642)	FY2008 Senate (H.R. 2642)	FY2008 enacted
Contingent emergency (P.L. 110- 161)									75,000
<i>Subtotal medical administration</i>	2,858,442	3,177,000	3,533,300	250,000	3,427,968	3,442,000	3,510,600	3,517,000	3,517,000
Medical facilities	3,297,669	3,569,000	3,594,000	3,569,000	3,569,533	3,592,000	4,100,000	4,092,000	3,592,000
Emergency appropriations (P.L. 110-28)	—	—	595,000	595,000	595,000	—	—	—	—
Contingent emergency (P.L. 110- 161)	—	—	—	—	—	—	—	—	508,000
<i>Subtotal medical facilities</i>	3,297,669	3,569,000	4,189,000	4,164,000	4,164,533	3,592,000	4,100,000	4,092,000	4,100,000
Medical and prosthetic research	412,000	399,000	412,000	412,000	413,980	411,000	480,000	500,000	411,000
Emergency appropriations (P.L. 110-28)	—	—	35,000	30,000	32,500	—	—	—	—
Contingent emergency (P.L. 110- 161)	—	—	—	—	—	—	—	—	69,000
<i>Subtotal medical and prosthetic research</i>	412,000	399,000	447,000	442,000	446,480	411,000	480,000	500,000	480,000
Total VHA appropriations (without collections)	29,340,517	32,657,000	33,996,282	33,999,131	33,958,013	34,612,671	37,122,000	37,213,220	37,201,220
Medical care cost collection (MCCF)	2,170,000	2,329,000	2,329,000	2,329,000	2,329,000	2,414,000	2,414,000	2,414,000	2,414,000
Total: VHA (appropriations and collections)	\$31,510,517	\$34,986,000	\$36,325,282	\$36,328,131	\$36,287,013	\$37,026,671	\$39,536,000	\$39,627,220	\$39,615,220

Sources: Table prepared by the Congressional Research Service based on H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H.Rept. 109-359; H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; *Congressional Record*, vol. 153, May 24, 2007, H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153, (September 7, 2007), S11271-S11278; and *Congressional Record*, vol. 153 (December 17, 2007), pp.H16249-H16431.

a. P.L. 110-161 (H.R. 2764) transferred \$66 million from the FY2007 medical services account to the construction major, projects account for FY2007.

Table 6. Appropriations for VA Construction Projects, FY2006-FY2008

(\$ in thousands)

	FY2006 Enacted	FY2007 enacted	FY2008 Request	FY2008 House (H.R. 2642)	FY2008 Senate (H.R. 2642)	FY2008 enacted
Construction, major projects ^a	\$607,100	\$465,000 ^b	\$727,400	\$1,410,800	\$727,400	\$727,400
Emergency Appropriations—Gulf Coast Hurricanes (P.L. 109-148)	367,500	—	—	—	—	—
Emergency Appropriations—Defense, the Global War on Terror, and Hurricane Recovery (P.L. 109-234)	585,919	—	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	341,700
Subtotal construction, major projects	1,560,519	465,000	727,400	1,410,800	727,400	1,069,100
Construction, minor projects ^c	198,937	198,937	233,396	615,000	751,398	233,396
Emergency Appropriations—Gulf Coast Hurricanes (P.L. 109-148)	1,800	—	—	—	—	—
Emergency appropriations—U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability (P.L. 110-28)	—	326,000	—	—	—	—
Contingent emergency (P.L. 110-161)	—	—	—	—	—	397,139
Subtotal construction, minor projects	200,737	524,937	233,396	615,000	751,398	630,535
Grants for construction of state extended care facilities ^d	85,000	85,000	85,000	165,000	250,000	85,000

	FY2006 Enacted	FY2007 enacted	FY2008 Request	FY2008 House (H.R. 2642)	FY2008 Senate (H.R. 2642)	FY2008 enacted
Contingent emergency (P.L. 110-161)	—	—	—	—	—	80,000
Subtotal Grants for construction of state extended care facilities	85,000	85,000	85,000	165,000	250,000	165,000
Total	\$1,846,256	\$1,074,937	\$1,045,796	\$2,190,800	\$1,728,798	\$1,864,635

Sources: Table prepared by CRS based on H.Rept. 109-464; H.Rept. 109-494; S.Rept. 109-286; P.L. 110-5; H.Rept. 110-64; S.Rept. 110-37; H.Rept. 110-60; *Congressional Record*, vol. 153, May 24, 2007, H5786-H5787; H.Rept. 110-186; S.Rept. 110-85; *Congressional Record*, vol. 153, September 7, 2007, S11271-S11278; and *Congressional Record*, vol.153 (December 17, 2007), pp. H16249-H16431.

Note: This table excludes grants for construction of state veterans cemeteries.

- This account provides funds for constructing, altering, extending, and improving any VA facility, including planning, assessments of needs, architectural and engineering services, CARES projects, and site acquisition, where the estimated cost of a project is \$10 million or more or where funds for a project were made available in a previous major project appropriation. Emphasis is placed on correction of safety code deficiencies in existing VA medical facilities.
- The initial amount enacted for FY2007 was \$399 million. P.L. 110-161 (H.R. 2764) transferred \$66.0 million from the FY2007 medical services account to the construction, major projects account for FY2007.
- This account provides funds for constructing, altering, extending and improving any VA facility, including planning, architectural and engineering services, CARES projects, and site acquisition, where the estimated cost of a project is less than \$10 million. VA medical center projects that need minor improvements costing \$500,000 or more are funded from this account.
- This account provides grants to states to acquire or construct state nursing home and domiciliary facilities, and to remodel, modify, or alter existing hospitals, nursing homes, and domiciliary facilities in state homes. A grant may not exceed 65% of the total cost of the project. P.L. 102-585 granted permanent authority for this program, and P.L. 104-262 added Adult Day Health Care as another level of care that may be provided by state homes. This is a no-year account.

Key Budget Issues

In its FY2008 budget request, the Administration has put forward several legislative proposals. These proposals are similar to previous ones included in the Administration's budget requests for FY2003, FY2004, FY2005, FY2006, and FY2007 and rejected by Congress each year.⁵⁰ However, unlike previous budget proposals, revenue from the proposals in the FY2008 budget request would not be deposited in the Medical Care Collections Fund (MCCF), but would be classified as mandatory receipts to the Treasury. Aside from the Administration's budget proposals, the House and Senate Appropriations Committees have expressed concern on the long-

⁵⁰ In FY2003, the VA proposed a \$1,500 deductible for all Priority Group 7 veterans for nonservice-connected disabilities. For proposals included in FY2004, FY2005, FY2006, and FY2007, see CRS Report RL32548, *Veterans' Medical Care Appropriations and Funding Process*, by Sidath Viranga Panangala; CRS Report RL32975, *Veterans' Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala; and CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

term cost of providing health care for veterans and the Administration's inability to accurately estimate the future cost of providing those services.⁵¹

The President's FY2008 budget request includes three major policy proposals:

- Assess a tiered annual enrollment fee for all Priority 7 and 8 veterans based on the family income of the veteran.
- Increase pharmaceutical co-payments from \$8 to \$15 (for each 30-day prescription) for all enrolled veterans in Priority Groups 7 and 8.
- Bill veterans receiving treatment for nonservice-connected conditions for the entire co-payment amount.

A detailed description of these budget proposals follows.

Assess an Annual Enrollment Fee

The Administration is proposing a tiered annual enrollment fee, which is structured to charge \$250 for Priority 7 and 8 veterans with family incomes from \$50,000 to \$74,999; \$500 for those with family incomes from \$75,000 to \$99,999; and \$750 for those with family incomes equal to or greater than \$100,000. The VA has estimated that this proposal would contribute more than \$138 million to the Treasury annually, beginning in FY2009, and will increase revenue by \$526 million over five years.

The MILCON-VA Appropriation Act (P.L. 110-161) *does not* include any bill language that would give the VA the authority to impose enrollment fees.

Increase Pharmacy Co-payments

The Administration proposes increasing the pharmacy co-payments from \$8 to \$15 for all enrolled Priority Group 7 and Priority Group 8 veterans whenever they obtain medication from the VA on an outpatient basis for the treatment of a nonservice-connected condition. The Administration put forward this proposal in its FY2004, FY2005, FY2006, and FY2007 budget requests as well, but did not receive any approval from Congress. At present, veterans in Priority Groups 2-8 pay \$8 for a 30-day supply of medication, including over-the-counter medications.⁵²

The Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) authorized the VA to charge most veterans \$2 for each 30-day supply of medication furnished on an outpatient basis for treatment of a nonservice-connected condition. The Veterans Millennium Health Care and Benefits Act of 1999 (P.L. 106-117) authorized the VA to increase the medication co-payment amount and establish annual caps on the total amount paid, to eliminate financial hardship for veterans enrolled in Priority Groups 2-6.⁵³ When veterans reach the annual cap, they continue to receive medications without making a co-payment.

⁵¹ U.S. Congress, House Committee on Appropriations, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2008*, report to accompany H.R. 2642, 110th Congress, 1st session, H.Rept. 110-186, p.14.

⁵² The following veterans are exempt from paying copayments: veterans receiving a pension for a nonservice-connected disability from the VA; veterans with incomes below \$10,929 (if no dependents) and \$14,313 (with one dependent plus \$1,866 for each additional dependent); veterans receiving care for conditions such as Agent Orange or Military Sexual Trauma, and combat veterans within two years of discharge; and veterans who are former POWs.

⁵³ This law allowed the VA to increase the copayment amount for each 30-day or less supply of medication provided on an outpatient basis (other than medication administered during treatment) for treatment of a nonservice-connected condition. Accordingly, the VA increased the co-payment amount from \$2 to \$7. The medication co-payment charge

On November 15, 2005, the VHA issued a directive stating that effective January 1, 2006, the medication co-payment will be increased to \$8 for each 30-day supply of medication furnished on an outpatient basis for treatment of a nonservice-connected condition, and that the annual cap for veterans enrolled in Priority Groups 2-6 will be \$960.⁵⁴ There is no cap for veterans in Priority Groups 7 and 8 (see **Appendixes B and C**). The VA estimates that if the current proposal to raise the co-payment were enacted, it would contribute \$311 million to the Treasury in FY2008 and will increase revenue by \$1.6 billion over five years. The MILCON-VA Appropriation Act (P.L. 110-161) *does not* include any bill language that would give the VA the authority to increase co-payments.

Impact of Fee Proposals

According to VA estimates, of the 5.8 million unique patients that it expects to see in 2008, 111,000 may choose not to use the system if an enrollment fee is imposed and the pharmacy copays are increased.

Third-Party Offset of First-Party Debt

The Administration is requesting that Congress amend the VA's statutory authority by eliminating the practice of reducing first-party co-payment debts with third-party health-insurance collections. The VA asserts that this proposal would align the VA with the DOD health-care system for military retirees and with the private sector.

With the enactment of P.L. 99-272 in 1986, Congress authorized the VA to collect payments from third-party health insurers for the treatment of veterans with nonservice-connected disabilities; it also established co-payments from veterans for this care.⁵⁵ Under current law, the VA is authorized to collect from third-party health insurers to offset the cost of medical care furnished to a veteran for the treatment of a nonservice-connected condition.⁵⁶ If the VA treats an insured veteran for a nonservice-connected disability, and the veteran is also determined by the VA to have co-payment responsibilities, the VA will apply the payment collected from the insurer to satisfy the veteran's co-payment debt related to that treatment.

Under the current co-payment billing process, in cases where the cost of a veteran's medical care for a nonservice-connected condition appears to qualify for billing under reimbursable insurance and co-payment, the VA medical facilities sends the bill to the insurance provider. The veteran's co-payment obligation is placed on hold for 90 days pending payment from the third-party payer. If no payment is received from the third-party payer within 90 days, a bill is sent to the veteran for the full co-payment amount. However, when insurers reimburse the VA after the 90-day period, the VA must absorb the cost of additional staff time for processing a refund if the veteran has already paid the bill. On all insurance policies, the entire amount of the claim payment is applied first to the co-payment. The veteran is then billed only for the portion of the co-payment not covered by the insurance reimbursement and the portion of the co-payment for services not covered by the veteran's insurance plan (see **Figure 2**).

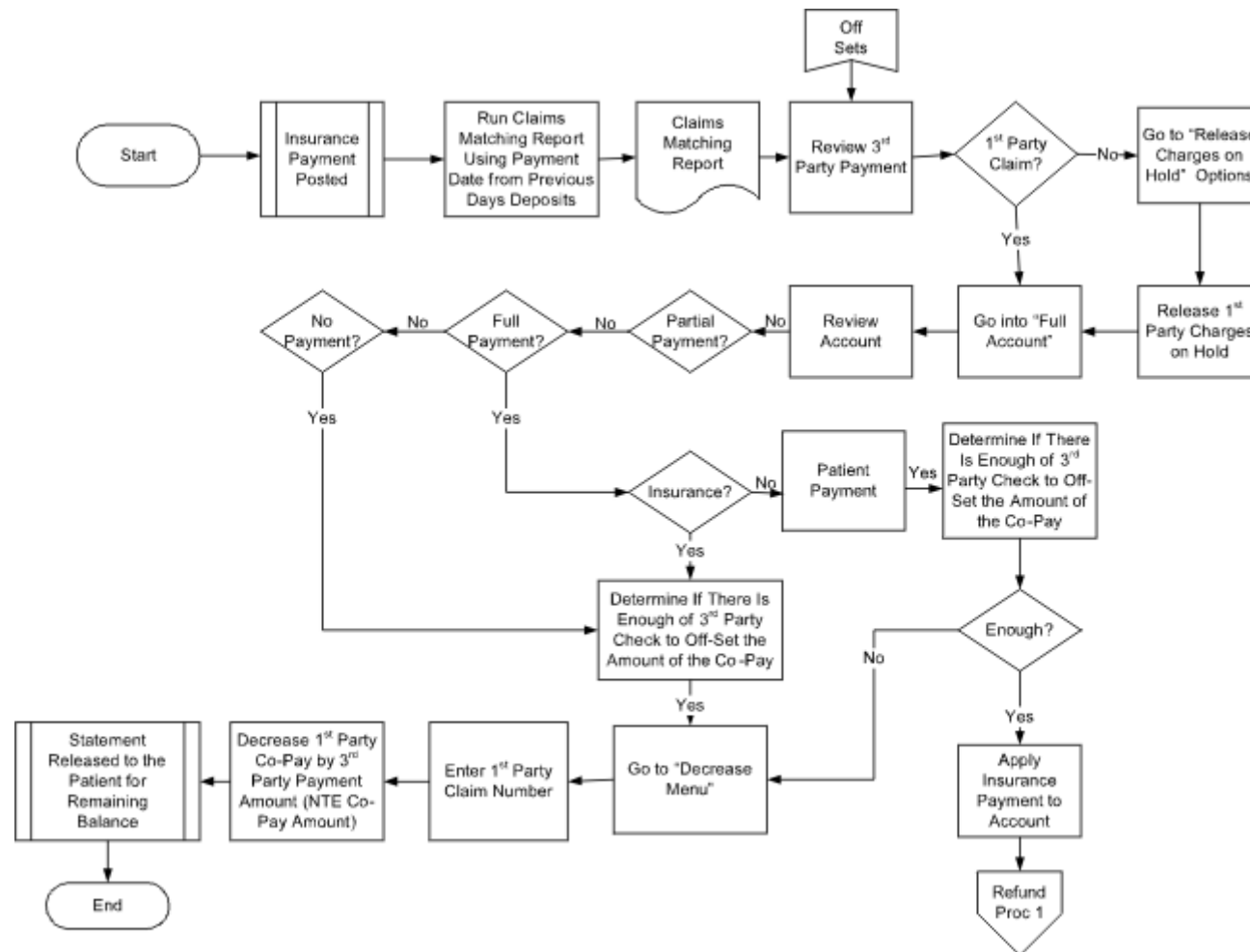
for each subsequent calendar year after 2002 is established by using the prescription drug component of the Medical Consumer Price Index. When an increase occurs, the co-payment increases in whole dollar amounts. The amount of the annual cap increases \$120 for each \$1 increase in the co-payment amount.

⁵⁴ VHA Directive 2005-052, *Implementation of Medication Copayment Changes*, November 15, 2005.

⁵⁵ Consolidated Omnibus Budget Reconciliation Act of 1985, 100 Stat. 372, 373, 383.

⁵⁶ 38 U.S.C. §1729; 38 U.S.C. §1710; and 38 U.S.C. 1722A.

Figure 2. Present Co-payment Process



Source: Department of Veterans Affairs.

Under the Administration's proposal, veterans receiving medical care services for treatment of non-service-connected disabilities will receive a bill for their entire co-payment, and the co-payment will not be reduced by collection recoveries from third-party health plans. This proposal would apply to all veterans who make co-payments.

According to VA estimates, this proposal will increase revenue by \$44 million in FY2008 and \$217 million over five years. The House and Senate Appropriations Committees have not addressed this issue because it is an issue in the purview of the authorizing committees.

Future Cost of Veterans' Health Care

On February 15, 2007, the Congressional Budget Office (CBO) testified that "assuming no major changes in policy and no major changes in enrollment trends ... that [VHA] medical spending would increase from \$35 billion in 2007 to \$66 billion in 2025, or 88 percent cumulative real growth. That increase implies annual real growth that averages 3.6 percent over the period."⁵⁷ The House and Senate Appropriations Committees have expressed concern that the President's budget has not accurately projected the future cost of health care for veterans from FY2008-FY2012. Furthermore, the House Appropriations Committee expressed doubt in the actuarial model currently used to project health-care demand for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. The House Appropriations Committee has included a general provision in H.R. 2642 directing the CBO to submit a report projecting the annual funding level necessary for the VHA to continue providing health care for veterans from FY2009 through FY2012.

⁵⁷ Statement of Allison Percy, Principal Analyst, on the Future Medical Spending by the Department of Veterans Affairs, before the House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, February 15, 2007.

Appendix A. Priority Groups and Their Eligibility Criteria

Priority Group 1

Veterans with service-connected disabilities rated 50% or more disabling

Priority Group 2

Veterans with service-connected disabilities rated 30% or 40% disabling

Priority Group 3

Veterans who are former POWs

Veterans awarded the Purple Heart

Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty

Veterans with service-connected disabilities rated 10% or 20% disabling

Veterans awarded special eligibility classification under Title 38, U.S. C., Section 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

Veterans who are receiving aid and attendance or housebound benefits

Veterans who have been determined by the VA to be catastrophically disabled

Priority Group 5

Nonservice-connected disabled veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA Means Test thresholds

Veterans receiving VA pension benefits

Veterans eligible for Medicaid benefits

Priority Group 6

Compensable 0% service-connected disabled veterans

World War I veterans

Mexican Border War veterans

Veterans solely seeking care for disorders associated with

—exposure to herbicides while serving in Vietnam; or

—ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or

—for disorders associated with service in the Gulf War; or

—for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.

Priority Group 7

Veterans who agree to pay specified co-payments who have income and/or net worth *above* the VA Means Test threshold and income *below* the HUD geographic index

—Subpriority a: Noncompensable 0% service-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date

—Subpriority c: Nonservice-connected disabled veterans who were enrolled in the VA Health Care System on a specified date and who have remained enrolled since that date.

—Subpriority e: Noncompensable 0% service-connected disabled veterans not included in Subpriority a above

—Subpriority g: Nonservice-connected disabled veterans not included in Subpriority c above

Priority Group 8

Veterans who agree to pay specified co-payments with income and/or net worth *above* the VA Means Test threshold and the HUD geographic index

—Subpriority a: Noncompensable 0% service-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date

—Subpriority c: Nonservice-connected disabled veterans enrolled as of January 16, 2003 and who have remained enrolled since that date

—Subpriority e: Noncompensable 0% service-connected disabled veterans applying for enrollment after January 16, 2003

Source: Department of Veterans Affairs.

Note: Service-connected disability means with respect to disability, that such disability was incurred or aggravated in the line of duty in the active military, naval, or air service.

Appendix B. Veterans' Payments for Health-Care Services, by Priority Group

	Copayments					Insurance Billing	Humanitarian Emergency Billing
	Inpatient		Out- patient	Medication ^a			
	Geographic Means Test Copayment	VA Means Test					
Priority Group 1	No	No	No	No	Yes, but only if care was for nonservice- connected condition	No	
Priority Groups 2, 3, ^b 4 ^c	No	No	No	Yes, but only for veterans with less than 50% service connected disability and medication is for nonservice-connected condition. Former POWs are exempt from all medications co-payments	Yes, but only if care was for nonservice- connected condition	No	
Priority Group 5	No	No	No	Yes	Yes, but only if care was for nonservice- connected condition	No	
Priority Group 6 (WWI, and 0% service-connected compensable)	No	No	No	Yes	Yes, but only if care was for nonservice- connected condition	No	
Priority Group 6 (Veterans receiving care for exposure or experience) ^d	No	No ^d	No ^d	No ^d	Yes, but only if care was for nonservice- connected condition	No	
Priority Group 7a	Yes	No	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice- connected condition	No	
Priority Group 7c	Yes	No	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice- connected condition	No	

Copayments						
	Inpatient		Out-patient	Medication ^a	Insurance Billing	Humanitarian Emergency Billing
	Geographic Means Test Copayment	VA Means Test				
Priority Group 8a	No	Yes	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition	No
Priority Group 8c	No	Yes	Yes	Yes, but only if care was for nonservice-connected condition	Yes, but only if care was for nonservice-connected condition	No

Source: Table prepared by CRS based on information from the Department of Veterans Affairs.

Notes: Priority Group 7a and 7c veterans have income above the VA Means Test threshold but below the Geographic Means Test threshold and are responsible for 20% of the inpatient co-payment and 20% of the inpatient per diem co-payment. The geographic means test co-payment reduction does not apply to outpatient and medication co-payment, and veterans will be assessed the full applicable co-payment charges. Note that reduced inpatient co-payments can apply to veterans in Priority Groups 4 and 6 based on the income of the veteran.

Priority Group 8a and 8c veterans have income above the VA Means Test threshold and above the Geographic Means Test threshold. Veterans enrolled in this priority group are responsible for the full inpatient co-payment and the inpatient per diem co-payment for care of their nonservice-connected conditions. Veterans in this priority group are also responsible for outpatient and medication co-payments for care of their nonservice-connected conditions.

- An annual medication co-payment cap has been established for veterans enrolled in Priority Groups 2-6. Medication will continue to be dispensed after co-payment cap is met. An annual co-payment cap has not been established for veterans enrolled in Priority Groups 7 or 8.
- Veterans in receipt of a Purple Heart are in Priority Group 3. This change occurred with the enactment of the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) on Nov. 30, 1999.
- Priority Group 7 veterans who are determined to be catastrophically disabled and who are placed in Priority Group 4 for treatment are still subject to the co-payment requirements as a Priority Group 7 veteran.
- Priority Group 6—veterans claiming exposure to Agent Orange; veterans claiming exposure to environmental contaminants; veterans exposed to Ionizing Radiation; combat veterans within two years of discharge from the military; veterans who participated in Project 112/SHAD; veterans claiming military sexual trauma; and veterans with head and neck cancer who received nasopharyngeal radium treatment while in the military are subject to co-payments when their treatment or medication is not related to their exposure or experience. The initial registry examination and follow-up visits to receive results of the examination are not billed to the health insurance carrier and are not subject to co-payments. However, care provided that is not related to exposure, if it is nonservice-connected, will be billed to the insurance carrier and co-payments can apply.

Appendix C. Financial Income Thresholds for VA Health-Care Benefits

Veterans with—	Free VA prescriptions and travel benefits for veterans with incomes of—	Free VA inpatient and outpatient care for veterans with incomes of—
No dependents	\$10,929 or less	\$27,790 or less
1 dependent	\$14,313 or less	\$33,350 or less
2 dependents	\$16,179 or less	\$35,216 or less
3 dependents	\$18,045 or less	\$37,082 or less
4 dependents	\$19,911 or less	\$38,948 or less
For each additional dependent, add:	\$1,866	\$1,866

Source: Department of Veterans Affairs.

Appendix D. VHA Appropriations for FY2005 and FY2006

(\$ in thousands)

Program	FY2005 request	FY2005 House	FY2005 Senate	FY2005 enacted	FY2006 request	FY2006 House	FY2006 Senate	FY2006 enacted
Medical services	—	\$19,498,600	\$19,498,600 ^a	\$19,316,995	\$19,995,141	\$20,995,141	\$21,331,011	\$21,322,141
Supplemental appropriations (P.L. 108-324)	\$38,283	—	—	38,283	—	—	—	—
Supplemental appropriations	975,000 ^b	975,000 ^c	1,500,000 ^d	1,500,000 ^e	—	—	—	—
Emergency appropriations	—	—	—	—	1,977,000 ^f	—	1,977,000 ^g	1,225,000 ^h
Emergency appropriations-Gulf Coast Hurricanes (P.L. 109- 148)	—	—	—	—	198,265	—	—	198,265
Emergency appropriations- Avian Flu Pandemic (P.L. 109- 148)	—	—	—	—	27,000	—	—	27,000
Subtotal medical services	1,013,283	20,473,600	20,998,600	20,855,278	22,197,406	20,995,141	23,308,011	22,772,406
Medical administration	—	4,705,000	4,705,000	4,667,360	4,517,874	4,134,874	2,858,442	2,858,442
Supplemental appropriations (P.L. 108-324)	1,940	—	—	1,940	—	—	—	—
Subtotal medical administration	1,940	4,705,000	4,705,000	4,669,300	4,517,874	4,134,874	2,858,442	2,858,442
Medical facilities	—	3,745,000	3,745,000	3,715,040	3,297,669	3,297,669	3,297,669	3,297,669
Supplemental appropriations (P.L. 108-324)	46,909	—	—	46,909	—	—	—	—
Subtotal medical facilities	46,909	3,745,000	3,745,000	3,761,949	3,297,669	3,297,669	3,297,669	3,297,669
Medical and prosthetic research	384,770	384,770	405,593	402,348	393,000	393,000	412,000	412,000
Information technology	—	—	—	—	—	—	1,456,821	—
Medical care ⁱ	26,748,600	—	—	—	—	—	—	—
Total VHA appropriations (without collections)	28,195,502	28,308,370	28,854,193	29,688,875	30,405,949	28,820,684	31,332,943	29,340,517

Program	FY2005 request	FY2005 House	FY2005 Senate	FY2005 enacted	FY2006 request	FY2006 House	FY2006 Senate	FY2006 enacted
Medical care cost collection (MCCF) ⁱ	2,002,000	2,002,000	2,002,000	1,985,984	2,170,000	2,170,000	2,170,000	2,170,000
Total: VHA (appropriations and collections)	\$30,197,502	\$31,310,370	\$30,856,193	\$31,674,859	\$32,575,949	\$30,990,684	\$33,502,943	\$31,510,517

Source: Table prepared by the Congressional Research Service based on H.Rept. 108-674; S.Rept. 108-353; H.Rept. 109-95; S.Rept. 109-105; H.Rept. 109-305; H.Rept. 109-359; and House Appropriations Committee data.

Notes: Appropriation amounts for FY2005 adjusted to account for the 0.8% across-the-board reduction in most discretionary accounts as called for in Division J, Section 122 (a)(1) of P.L. 108-447. Supplemental appropriations for FY2005 are not subject to the 0.8% across-the-board reductions. Appropriation amounts for FY2006 are *not* subject to any cross-the-board reductions as stipulated in Division B, Title III, Section 3801(c)(2) of P.L. 109-148.

- a. This amount includes \$1.2 billion designated as an emergency requirement.
- b. On June 30, 2005, the Administration requested an additional \$975 million for medical services for FY2005.
- c. On June 30, 2005, the House passed H.R. 3130.
- d. On June 29, 2005, the Senate passed an amendment to H.R. 2361, the Department of the Interior, Environment, and Related Agencies Appropriations bill, 2006 to add \$1.5 billion in emergency funds for medical services.
- e. On August 2, 2005, the FY2006 Department of the Interior, Environment, and Related Agencies appropriations bill (H.R. 2361, P.L. 109-54) was signed into law.
- f. On July 14, 2005, the Administration requested an additional \$1.977 billion for medical services for FY2006.
- g. On July 21, 2005, the Senate Committee on Appropriations reported H.R. 2528 favorably out of committee (S.Rept. 109-105) and designated this amount as an emergency appropriation.
- h. On November 18, 2005, the House and Senate adopted the conference report (H.Rept. 109-305) to accompany H.R. 2528 and designated this amount as an emergency appropriation.
- i. This amount includes funding for medical services, medical administration, and medical facilities.
- j. Medical Care Cost Collection Fund (MCCF) receipts are restored to the VHA as an indefinite budget authority equal to the revenue collected, estimated to be \$1.985 billion in FY2005, \$2.17 billion in FY2006, and \$2.33 billion in FY2007.

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